

Enrollment “How To” Guide for Special Needs Plans (SNPs)

Attachment B

Data Elements Required to Complete the Enrollment Election

(Issued: 09-30-05, Effective Date: 09-30-05)

All data elements with a “Yes” in the “Required before enrollment complete” column are necessary in order for the enrollment to be considered complete.

Data Element		Required before enrollment complete?
1	MA Plan Name	Yes
2	MA Plan/Product/premium choice (if included)	Yes
3	Beneficiary Name	Yes
4	Beneficiary Date of Birth	Yes
5	Beneficiary Sex	Yes
6	Social Security Number	No
7	Beneficiary Telephone Number	No
8	Permanent Residence Address	Yes
9	Mailing Address	No
10	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No
11	E-mail Address	No
12	Beneficiary Medicare number	Yes
13	Additional Medicare information contained on sample Medicare card, or copy of card	No ¹
14	Plan Premium Payment Option	Yes
15	Response to ESRD Question	Yes
16	Response to long term care question	No
17	Response to other insurance COB information	Yes
18	Response to Medicaid question	Yes
19	Language preferences (Optional Field)	No

¹

An MA organization can not refuse to accept an enrollment form when an individual does not have his/her Medicare card available at the time s/he fills out an enrollment form; however, the enrollment form will not be considered complete until the MA organization has obtained evidence of entitlement to Medicare Part A and enrollment in Part B. We recognize that the MA organization needs, at a minimum, the Medicare number in order to verify entitlement to Part A and enrollment in Part B; we have accounted for the need for this data element under data element number 4.

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20	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No
21	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No
22	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No
23	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	No
24	Beneficiary signature and/or Authorized Representative Signature	Yes ²
25	Date of signature	No ³
26	Authorized representative contact information	Yes
27	Employer Name and Group Number	Yes
28	Question of which MA plan/premium the beneficiary is currently a member of and to which MA plan/premium the beneficiary is changing	Yes
29	Information regarding creditable coverage	Coming in Fall 2006

² For Employer Group MA enrollment elections, and some other CMS approved enrollment elections, a signature is not required.

³ The beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the MA organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element. For employer group MA elections, the "signature date" is the date the employer's process was completed as recorded.